NOTICE OF INDEPENDENT REVIEW DECISION

September 12, 2002

RE: MDR Tracking #: M2-02-0927-01
IRO Certificate #: 4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 49 year old male sustained a work-related injury on ___ when he was involved in a head-on MVA. He suffered fractured ribs, low back pain, left shoulder pain and right hip and neck pain. The treatment plan has consisted of arthroscopic shoulder surgery and conservative treatment including, medications, chiropractic care, physical therapy, pain management, epidural steroid injections and trigger point injections. The patient continues to complain of pain in the left shoulder, neck, low back, right groin and thigh.

Requested Service(s)

Four channel combination muscle stimulator and interferential unit

Decision

It has been determined that a four channel combination muscle stimulator and interferential unit are not medically necessary.

Rationale/Basis for Decision

The information presented for review was limited and was not sufficient to substantiate the medical necessity for a neuromuscular stimulator and interferential unit. A consultation dated 07/16/02 stated that "a TENS unit helps". In addition, the assessment/plan by ___ did not include a recommendation for a neuromuscular stimulator and interferential unit. Therefore, a neuromuscular stimulator and interferential unit are not medically necessary to treat this patient's condition.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,